Context for Medicare payment policy

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Chapter summary

This report's analyses of Medicare payment policies must be considered in the broader context of the nation's health care spending overall and the realities of the federal budget. Health care accounts for a large and growing share of total economic activity in the United States, nearly doubling as a share of gross domestic product (GDP) in the past 30 years, from 9.2 percent in 1980 to 17.9 percent in 2010. Growth in health care spending in 2010 slowed to the second lowest rate since 1960. However, projections of health care spending show it growing faster than GDP by 1.1 percentage points annually through 2020.

Growth in health care costs has a significant fiscal impact on federal, state, and local governments, as government payers directly sponsor nearly half of all health care spending. Furthermore, the federal government may be less able to provide financial support to fiscally strapped states as a result of its own long-term deficit picture. While the federal government's short-term fiscal outlook could modestly improve as the economy recovers, the United States faces an even more significant long-term deficit that needs to be addressed by cutting spending, by increasing revenue, or by some combination of the two. Growth in health care spending in the Medicare and Medicaid programs contributes materially to that deficit.

Medicare's spending projections over the next 10 years envision much smaller growth in spending (5.9 percent annually) than in recent history (8.8 percent in the 10 prior years), even as the number of Medicare beneficiaries will grow about twice as fast. This smaller growth is largely due to recent legislation

In this chapter

- Growth in health care spending: Trends

- Growth in health care spending is a challenge for public payers

- Growth in Medicare spending: Trends

- Changes in the population attaining Medicare eligibility

- Environmental scan of health care delivery system

- Reasons for growth in health care spending

- National and international variation in health care spending suggests inefficiencies

- Conclusion

that calls for smaller updates in the prices that Medicare pays relative to what was generally true in the past. Those smaller updates are largely in the form of a change in Medicare's prices to account for economy-wide multifactor productivity. However, the Medicare program still faces substantial deficits over the long term, and the Hospital Insurance trust fund is projected to be exhausted within 15 years. Medicare spending growth will also affect beneficiaries through cost sharing and premiums that are projected to grow faster than Social Security benefits.

Over the next 10 years, the Medicare population is projected to grow by a third. The average age of the Medicare population will decline slightly as the baby boom generation turns 65. The new beneficiaries may have fewer retirement assets as a result of the economic recession and may be more likely to still be working. Finally, new Medicare beneficiaries may be more receptive to managed care as a result of changes in the health insurance market.

The Medicare program has an important influence on the shape of the health care delivery system in the United States, and, conversely, trends in the delivery system will affect how the Medicare program develops. The success or failure of new systems to reform Medicare payment will depend on features in the health care system, such as industry structure and consolidation, innovations in payment systems, benefit structures, and other aspects of health care delivery.

Many researchers have credited the introduction, expansion, and diffusion of new technology with having the largest single effect on growth in health care spending. Researchers typically include nearly all changes in the practice of medicine in the definition of technology—the adoption of new technologies, diffusion to new populations, complementary and supplementary procedures, and changes in a person's demand for health care downstream of a particular intervention. Given the breadth of this term, other factors such as health insurance, incomes, health status, and prices have a comparatively smaller effect on growth in health care spending.

There are some indications that a share of health care dollars is misspent. There is significant variation in the use of health care in different regions in the United States, and yet the high-use regions are not clearly associated with better outcomes even when adjusting for health status, calling some of the use into question. In addition, comparisons between the United States and other countries suggest the potential to achieve similar levels of quality with lower spending. There are also indications that some share of spending may be misallocated; for example, there are notable differences in access to quality care for different demographic groups.

The current pressure from growth in health care spending combined with the rise in the number of beneficiaries and indications that potential savings are possible makes it incumbent on the Medicare program to spend limited funds wisely by providing incentives for beneficiaries to seek, and providers to deliver, high-value services. ■

MedPAC

FIGURE
1–1

Health care spending has grown more rapidly than GDP, with public financing making up nearly half of all funding
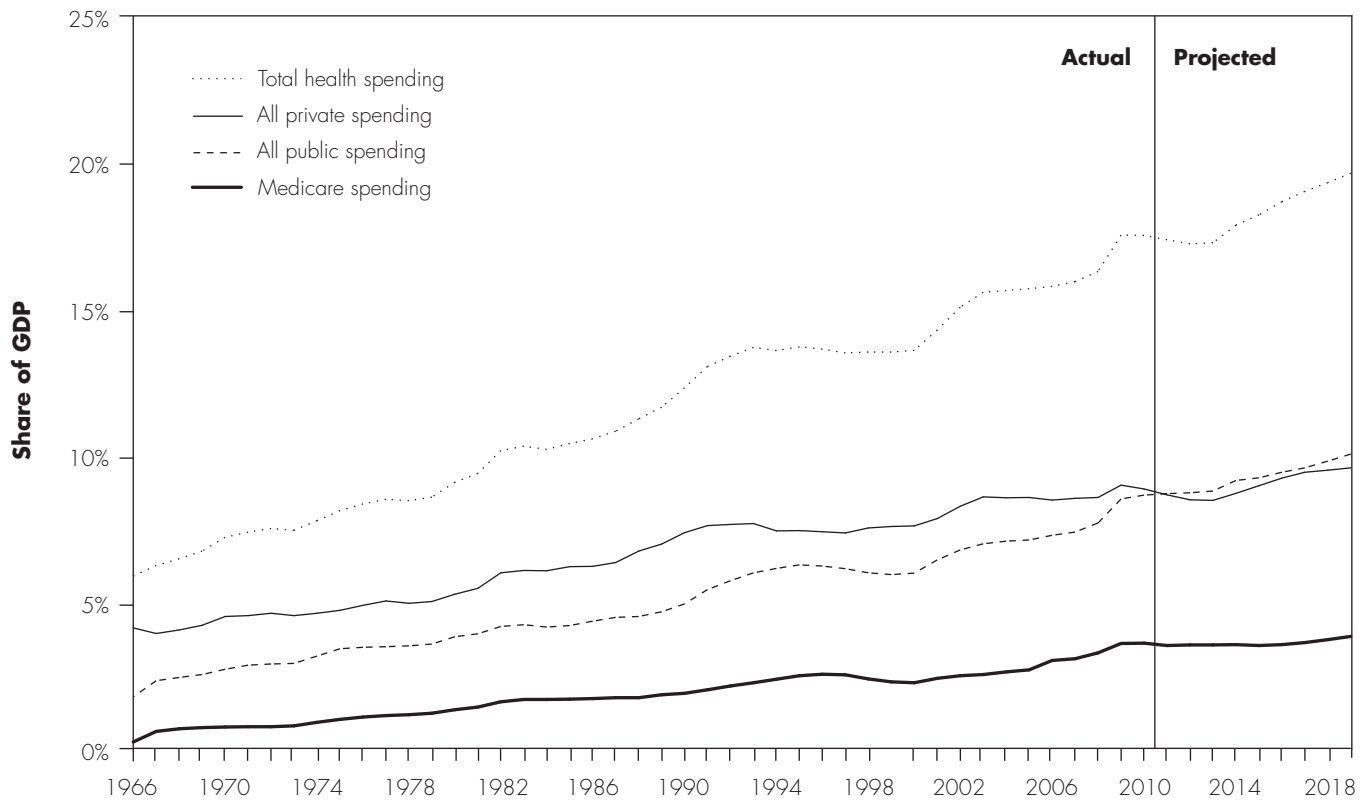
Note: GDP (gross domestic product). Medicare spending reflects current law, which includes the sustainable growth rate provisions cutting physician payment rates.

Source: Centers for Medicare & Medicaid Services, National Health Expenditures.

Introduction

This chapter describes the context for Medicare payment policy. It discusses the overall trends in health care spending at the national level, for public programs, and for the Medicare program itself; reviews changes in the Medicare population and in the health care market for payers and providers; discusses the generally accepted factors driving growth in health care spending; and discusses indicators of substantially misspent or misallocated health care dollars—namely, variations in quality that are particularly acute for certain demographic groups and higher per person spending compared with other countries.

Growth in health care spending: Trends

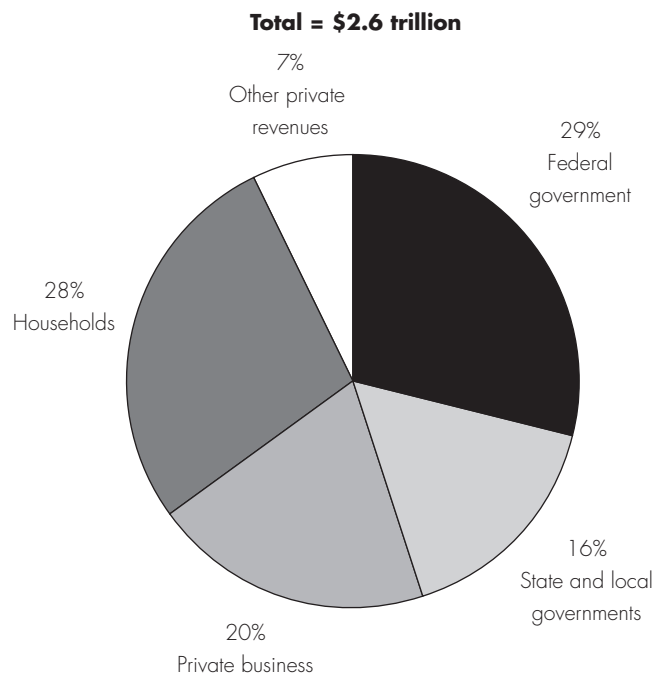Since the government began tracking the National Health Expenditure accounts in 1960, the average annual growth rate for per capita health care spending has been approximately 8.5 percent, or 2.6 percentage points higher than gross domestic product (GDP) per capita (Figure 1-1).[1] Even over shorter time periods that more heavily weight the low-growth managed care era of the 1990s, growth in health care spending exceeded growth in GDP by 2 percentage points from 1990 to 2010. In 2010, health care spending accounted for 17.9 percent of GDP, nearly twice what it was in 1980 (Martin et al. 2012). Nearer term effects of growth in health care spending include growth in health insurance premiums that exceeds growth in average wage and the projected exhaustion of the Medicare Hospital Insurance (HI) trust fund in 2024.

National health care spending

In 2010, individuals, government, and businesses spent $2.6 trillion on health care, corresponding to nearly $8,300 per person. Among all payers, in 2010, the largest share of personal spending on health care was for hospital (37 percent) and physician and clinical (24 percent) services,

**FIGURE
1–2**

**National health spending,
by sponsor, 2010**

Total = $2.6 trillion

Source: Centers for Medicare & Medicaid Services, National Health Accounts.

economy. Employment in this sector increased by 8.4 percent from January 2008 to December 2011, while employment outside the health sector was 5.8 percent below the January 2008 level (Figure 1-3). Employment growth varied by sector, increasing 4.9 percent in the hospital sector compared with an increase of over 20 percent in the home health sector over the four-year time period shown in Figure 1-3.
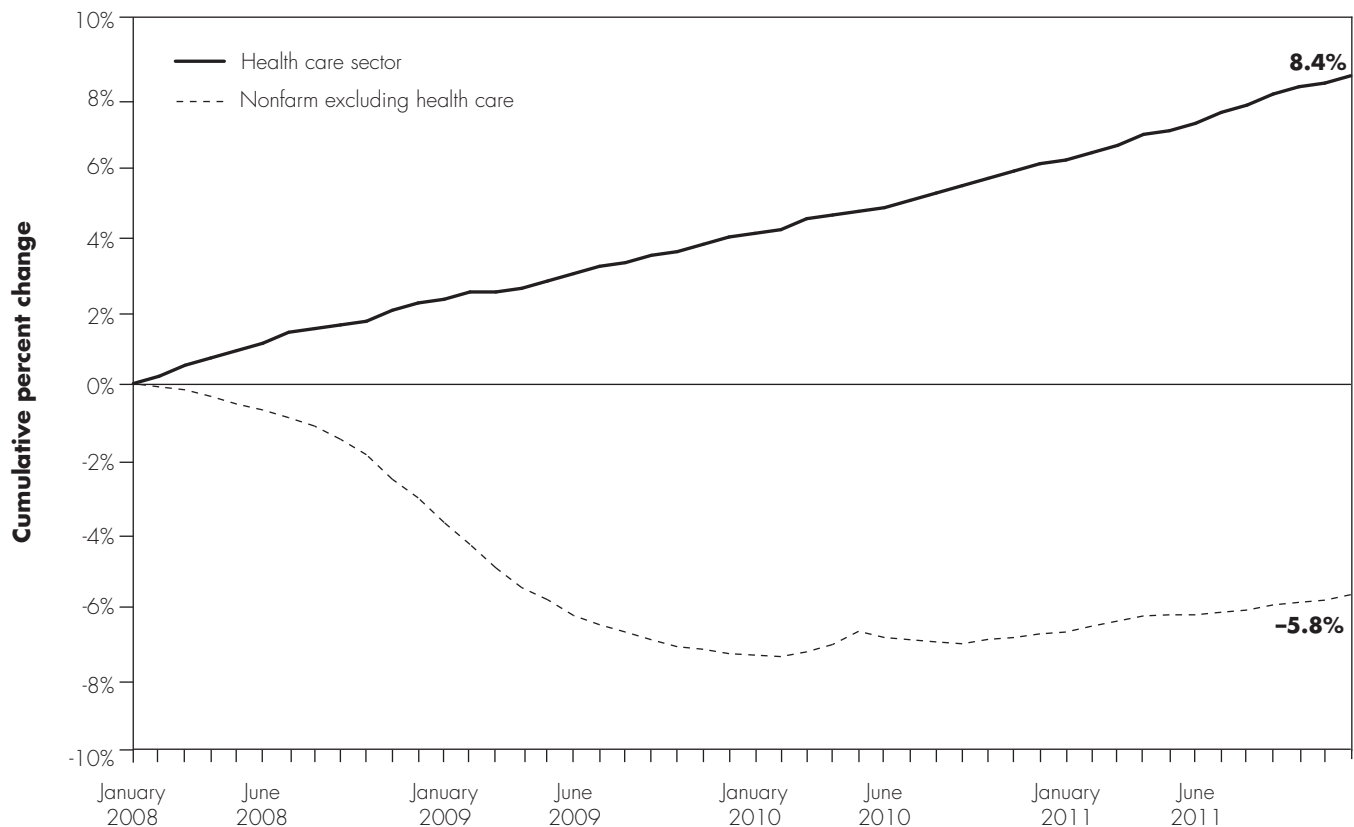
Projections show shift in type and source of coverage

The 10-year projections from National Health Expenditure data show a shift from uninsured to enrollment in other types of coverage, such as plans purchased through the new health insurance exchanges and Medicaid. Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are projected to cover 40 percent of the population by 2020, compared with 32 percent in 2010 (Keehan et al. 2011).

Growth in health care spending is a challenge for public payers

The financing challenges facing federal, state, and local governments as a result of the economic recession and population aging are magnified by growth in health care spending. Today, the government directly sponsors about 45 percent of all health care spending; after the Medicaid expansions and the health care exchanges are created in 2014, the government's share will increase to nearly 50 percent in 2020 (Keehan et al. 2011). The government also indirectly supports health care through tax incentives for employer-sponsored insurance.[2] Increases in the cost of private insurance could result in fewer people with private coverage, further pressuring public programs. Therefore, the need to slow growth in health care spending is one that state and local governments as well as the federal government share.

Like the federal government, states must find additional revenue to pay for higher enrollment in income assistance programs during the recession. States also have some unique features that make their fiscal problems different from those of the federal government. Nearly all states have balanced budget requirements, whereas the federal government can run yearly deficits. States also receive federal matching funds for Medicaid as well as temporary revenue sharing such as the State Fiscal Stabilization Fund and the increase in federal matching funds for Medicaid in

with smaller shares spent on prescription drugs (12 percent), nursing home care (7 percent), and home health (3 percent) services (Martin et al. 2012).

Slowdown in health care spending since 2008

National health expenditures grew at a near-historic low of 3.9 percent from 2009 to 2010, slightly higher than the prior low of 3.8 percent in 2009 (Martin et al. 2012). This amount is due to low growth in private health insurance and out-of-pocket spending as individuals lost their private insurance coverage and income growth slowed.

Total growth in Medicare spending was also relatively low, at 5.0 percent—much lower than the rates in 2008 and 2009 (8.0 percent and 7.0 percent, respectively) (Martin et al. 2012). The federal government (29 percent) and households (28 percent) were the largest direct sponsors of health spending, with private businesses following (20 percent) (Figure 1-2).

Health care employment

Despite the slowdown in health spending, the health care sector has still grown compared with other parts of the

FIGURE
1–3

Cumulative percent change in employment, 2008–2011

Source: Bureau of Labor Statistics, Current Employment Statistics.

the American Recovery and Reinvestment Act (Recovery Act) (Pew Center on the States 2010).
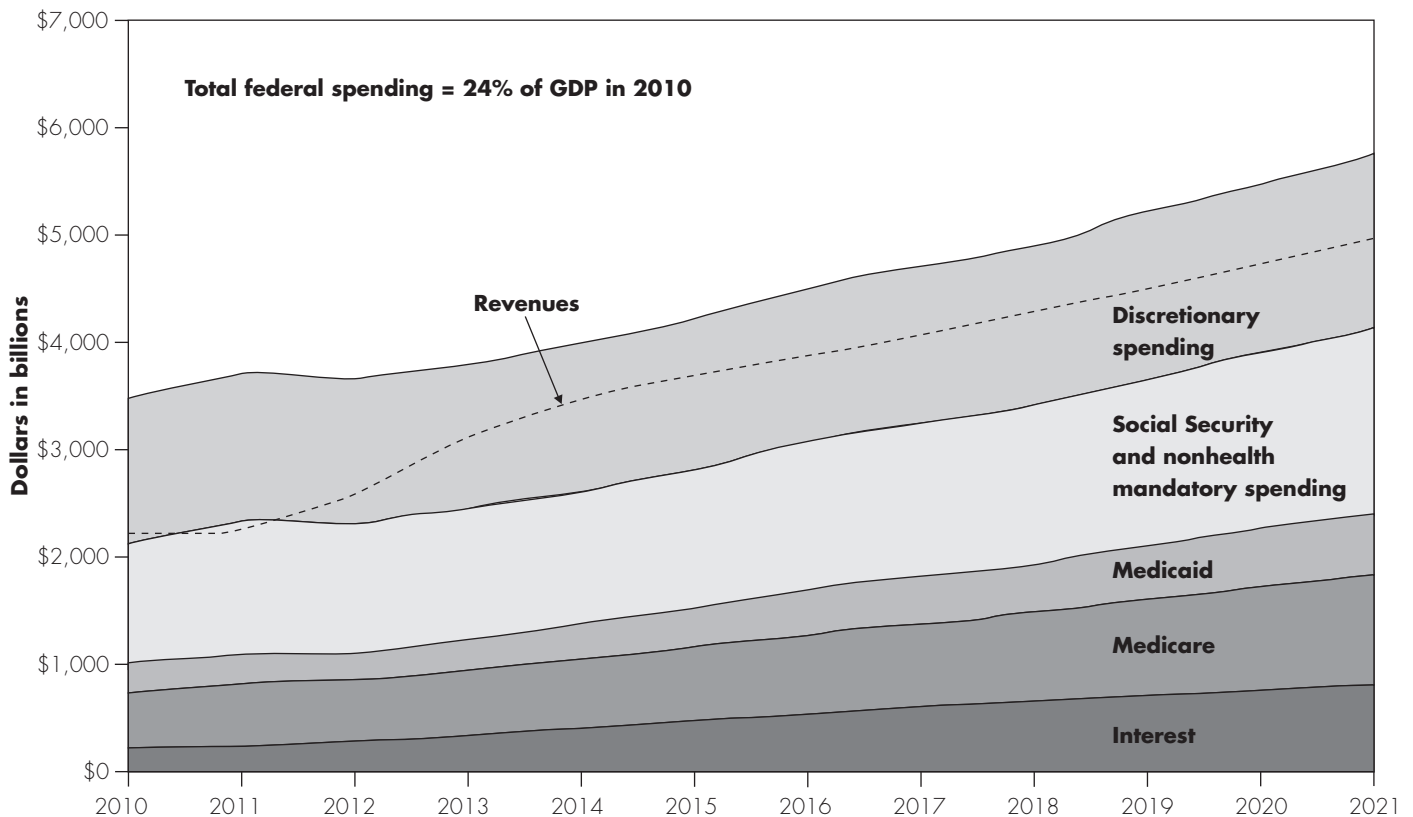
Medicaid dominates many states' fiscal outlooks

Medicaid spending accounts for 20 percent of all state spending, and the share exceeds 25 percent in nine states (Pew Center on the States 2010). In 2010, Medicaid covered 68 million people and CHIP covered an additional 7 million; together they accounted for over $400 billion in state and federal spending (Medicaid and CHIP Payment and Access Commission 2011c). Medicaid is a significant payer for some providers, accounting for 18 percent of hospital revenues and a third of nursing home revenues in 2009 (Medicaid and CHIP Payment and Access Commission 2011c). Overall, Medicaid directly funds about half of long-term care services and supports.

Federal matching funds for Medicaid range from 50 percent to 75 percent by state and type of service, with the

federal match averaging 57 percent (Medicaid and CHIP Payment and Access Commission 2011c). The Recovery Act temporarily increased the federal share of Medicaid, and this increase expired in June 2011. However, enrollment in Medicaid remains high because of the nature of income assistance programs—when the unemployment rate rises, Medicaid enrollment rises. Between 1999 and 2008, the number of Medicaid enrollees grew by 4.1 percent per year overall—with the number of children and adults growing by 4.2 percent and 6.2 percent per year, respectively, and the aged and disabled category growing more slowly at 2.4 percent per year (Medicaid and CHIP Payment and Access Commission 2011b).

The decline in state revenues resulting from the recent economic downturn and higher spending on assistance programs has focused the attention of some states on reducing their Medicaid expenditures. However, states must keep the eligibility requirements that were in place when the Patient Protection and Affordable Care Act

FIGURE
1–4

Ten-year budget projections show continued deficits

Total federal spending = 24% of GDP in 2010

Revenues

Discretionary spending

Social Security and nonhealth mandatory spending

Medicaid

Medicare

Interest

Dollars in billions

Note: The figure reflects current law, which includes the sustainable growth rate and expiration of the 2001 and 2003 tax cuts.

Source: Congressional Budget Office 2011 Budget and Economic Outlook.

(PPACA) was enacted in 2010 until 2014, when the Medicaid expansions go into effect. Therefore, states' ability to reduce or constrain Medicaid spending is largely limited to reducing provider payments, controlling pharmacy costs, and reducing benefits for some populations (Kaiser Family Foundation 2011).

Medicaid makes widespread use of managed care, particularly for the nondisabled population. In 2009, 71 percent of Medicaid enrollees received some form of managed care services during the year, and managed care accounted for 21 percent of Medicaid spending (Medicaid and CHIP Payment and Access Commission 2011a). This information implies that use of managed care is less prevalent among the higher cost Medicaid enrollees, such as the disabled and long-term care populations. From 1995 to 2009, the share of Medicaid enrollees in comprehensive, risk-based managed care plans grew from 15 percent to 47 percent (Medicaid and CHIP Payment and Access Commission 2011a).

Federal fiscal outlook

The federal government's spending on Medicare and Medicaid accounted for 23 percent of total federal spending in 2010, or $793 billion, and this amount is projected to grow to $1.608 trillion by 2021 (Figure 1-4).[3] The Congressional Budget Office (CBO) projected that spending for the major mandatory health care programs is projected to grow from 6 percent of GDP to 9 percent in 2035 (Congressional Budget Office 2011a). This share would be even higher if certain modifications were made to current law—for example, if the sustainable growth rate formula for physician payment were repealed and replaced with a mechanism for larger updates.

Beyond the short-term fiscal picture, which largely reflects the recent economic recession, is a much larger deficit over the long term. Increased health spending, driven both by the aging of the population and by growth in per capita health spending, is a major contributor to that deficit. As

FIGURE
1–5

Per enrollee annual growth in common benefits for Medicare and private health insurance, and GDP growth
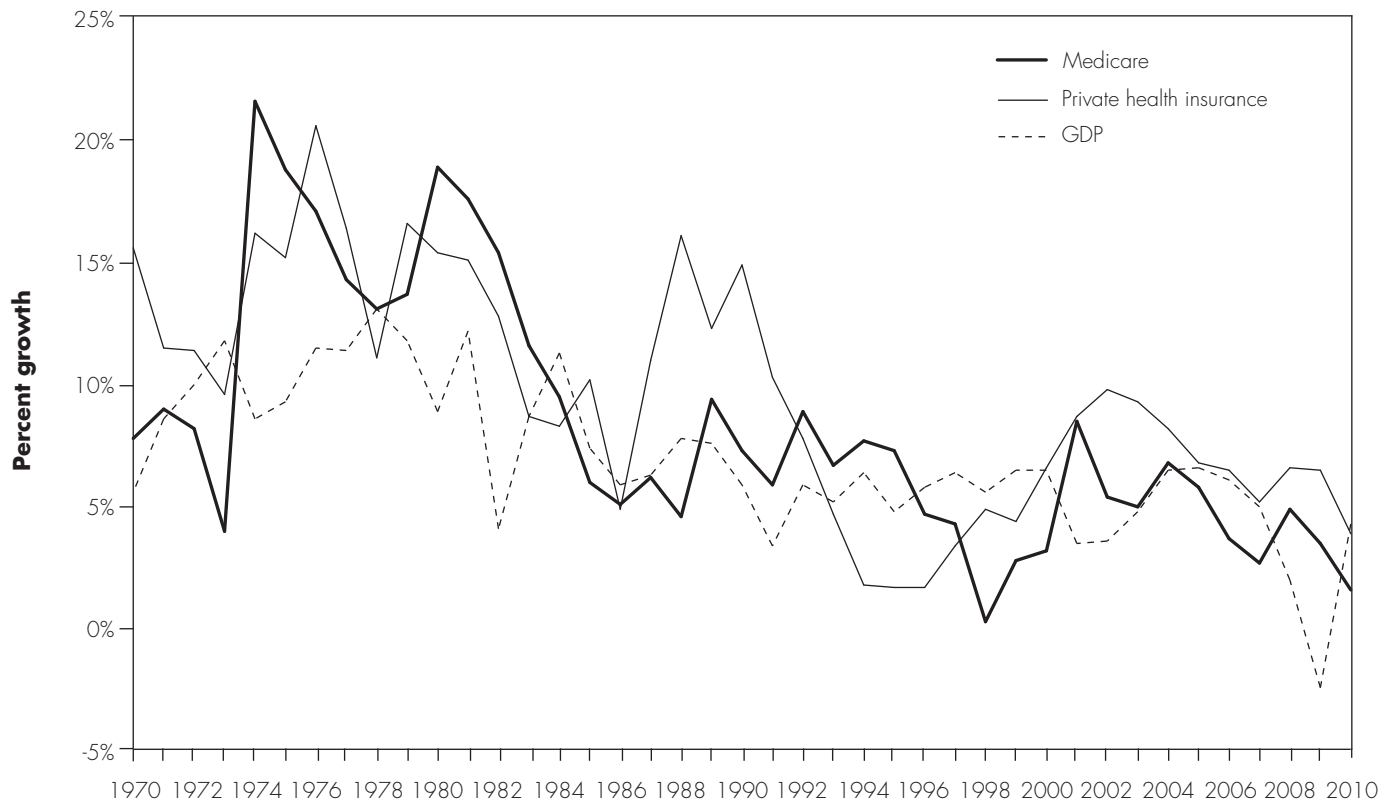
Note: GDP (gross domesic product). Common benefits are hospital services, physician and clinical services, other professional services, and durable medical products.

Source: Centers for Medicare & Medicaid Services, National Health Accounts.

seen in Table 1-1, over the short term, the growth in the number of Medicare beneficiaries and Medicaid recipients is of the same magnitude as the growth in health care spending. However, over the long term, CBO projects that growth in per beneficiary health care spending is the dominant driver in the growth in Medicare and Medicaid.[4] Further worsening the fiscal outlook is the increase in Social Security spending occurring over the same time frame and a decline in the working-age share of the population.

Growth in Medicare spending: Trends

When changes are made to account for the differences in population and in the benefit package, the overall growth rates for Medicare and for private insurance are similar, with growth in Medicare exceeding growth in private health

insurance in some years and the converse occurring in other years, although in recent years Medicare spending has been slightly lower (Figure 1-5). This similarity in the growth rates over the long term is notable because Medicare's benefits differ from the benefits in private plans, the health

TABLE
1–1

Sources of growth in major federal health care programs

Source	2010–2035	2010–2085
Age and demographic changes and changes in number of beneficiaries and recipients	48%	29%
Growth in spending per beneficiary and recipient	52	71

Source: Congressional Budget Office, *Long-Term Budget Outlook* 2011.

Projected Medicare average annual growth rates from 2011 to 2020

Category	Per beneficiary growth	Change in number of beneficiaries	Total spending growth
All Medicare	**3.0%**	**3.0%**	**5.9%**
Part A	1.6	3.0	4.8
Part B	2.7*	2.9	5.8
Part D	6.6	3.1	9.9
Medicare Advantage	2.0	–3.0	–0.8

Note: Medicare Advantage is also included in per capita growth for Part A, Part B, and Part D but not in the enrollment figures. Totals may not sum due to rounding.
*Part B estimates include the 30 percent payment cut for physicians in 2012 due to the sustainable growth rate provision. Under the Trustees' illustrative alternative scenario, per beneficiary Part B spending would grow by 5.2 percent annually (instead of 2.7 percent as under current law).

Source: 2011 annual report of the Boards of Trustees of the Medicare trust funds, Tables V.B1, III.A3, IV.C2, and IV. C3.

and demographics of the Medicare population differ from those of the privately insured population, and the distribution of services is different (see text box, opposite page, for a description of program financing).

Medicare spending over the next 10 years

The projected growth rates for the Medicare program from 2011 to 2020 are much lower than recent trends, even as the number of beneficiaries will increase about twice as fast as in the previous 10 years. The 2011 Trustees report projects that from 2011 through 2020 Medicare will grow by nearly 6 percent annually, of which 3.0 percent is due to growth in the number of beneficiaries and 3.0 percent is due to growth in spending per beneficiary (Table 1-2) (Boards of Trustees 2011). By contrast, over the past 10 years, total Medicare spending grew by 8.8 percent per year, of which 1.3 percent was due to the change in the

number of beneficiaries and 7.4 percent was due to growth in spending per beneficiary (see text box on p. 13 for a description of the sources of Medicare spending growth over the next 10 years).[5]

Growth rates for Part A and Part B are generally projected to be low compared with historical growth rates as a result of reductions in prices to account for economy-wide productivity, while Part D, which is not subject to reductions in prices for economy-wide productivity, is scheduled to grow at rates more in line with historical trends. The 2011 Trustees report projects that Medicare Advantage enrollment will decline throughout the next 10 years, largely as a result of the PPACA provisions that would reduce payments to Medicare Advantage plans (Boards of Trustees 2011).

Long-run Medicare projections

By 2085, the Medicare Trustees project that Medicare's share of GDP will approach 6.2 percent, from 3.7 percent today (Table 1-3).[6] Under an alternative Trustees' scenario (not shown), in which physician payments are updated by the Medicare Economic Index and productivity adjustments are phased out after being in effect for 10 years, Medicare's share of GDP would reach 8.0 percent by 2050 and 10.4 percent by 2080 (Shatto and Clemens 2011).

The Hospital Insurance trust fund currently runs a yearly deficit, which requires redeeming HI trust fund assets that are projected to be exhausted by 2024. Part B and Part D are financed through general revenue and premiums; as a result, these parts of Medicare do not have a trust fund exhaustion date. Given the burden of high federal deficits,

Medicare's share of GDP

Category	2011	2050	2085
All Medicare	**3.7%**	**5.9%**	**6.2%**
Part A	1.7	2.3	2.1
Part B	1.5	2.4	2.4
Part D	0.4	1.3	1.7

Note: GDP (gross domestic product). Percents may not sum to totals due to rounding.

Source: 2011 annual report of the Boards of Trustees of the Medicare trust funds, Table III.A2.

Medicare program financing

The Medicare program is funded through a mix of premiums and cost sharing, payroll taxes, general revenues, and other sources (Figure 1-6). In addition to its dedicated funding sources, in 2010, $205 billion in general revenue, equivalent to 19 percent of all income taxes collected by the government, went to support the Medicare program (Congressional Budget Office 2011a).

- *Part A is Medicare's Hospital Insurance (HI) benefit,* which covers acute hospitalizations and post-acute care. Part A is financed through a 2.9 percent payroll tax split between employers and employees as well as an additional 0.9 percent payroll tax on wages over $200,000 for single filers and $250,000 for married filers starting in 2013.

- *Part B is Medicare's supplementary medical insurance benefit,* and it covers outpatient hospital services and ambulatory care. Part B is financed through beneficiary premiums and general revenue. Starting in 2011, Medicare collects a fee from pharmaceutical manufacturers and this revenue is credited to Part B.

- *Part C is the Medicare Advantage program,* which contracts with private plans to offer Part A and Part B. Part C is funded through beneficiary premiums and transfers from Part A and Part B.

- *Part D is the part of Medicare's supplementary medical insurance benefit for outpatient pharmaceuticals,* and it is financed through beneficiary premiums and general revenue.

Nearly all parts of Medicare have some beneficiary cost sharing through deductibles and coinsurance. The Medicare program does not have a catastrophic limit on cost sharing, other than in Part D. ∎
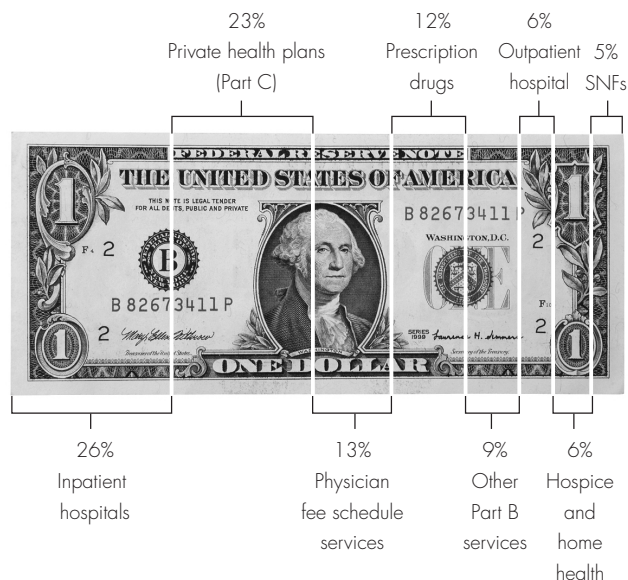

**FIGURE
1–6**

Sources and uses of funds for Medicare expenditures, 2011

**Sources of funds for Medicare expenditures**
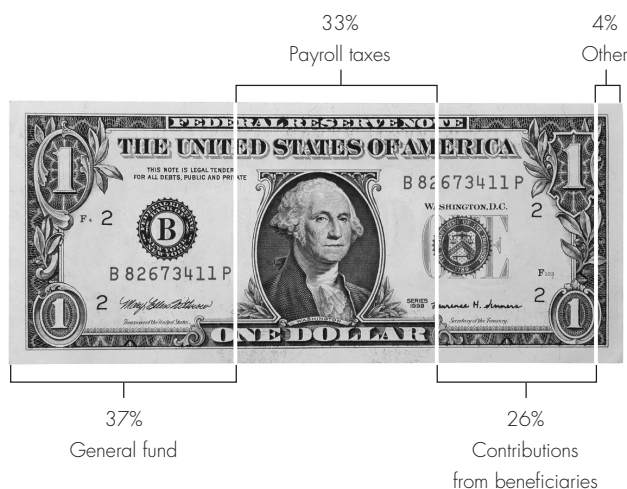
Uses of funds for Medicare expenditures

Note: SNF (skilled nursing facility). Sources of funds graphic includes beneficiary premiums and cost sharing. Uses of funds graphic does not include expenditures funded by beneficiary cost sharing.

Source: MedPAC analysis and the 2011 annual report of the Boards of Trustees of the Medicare trust funds.
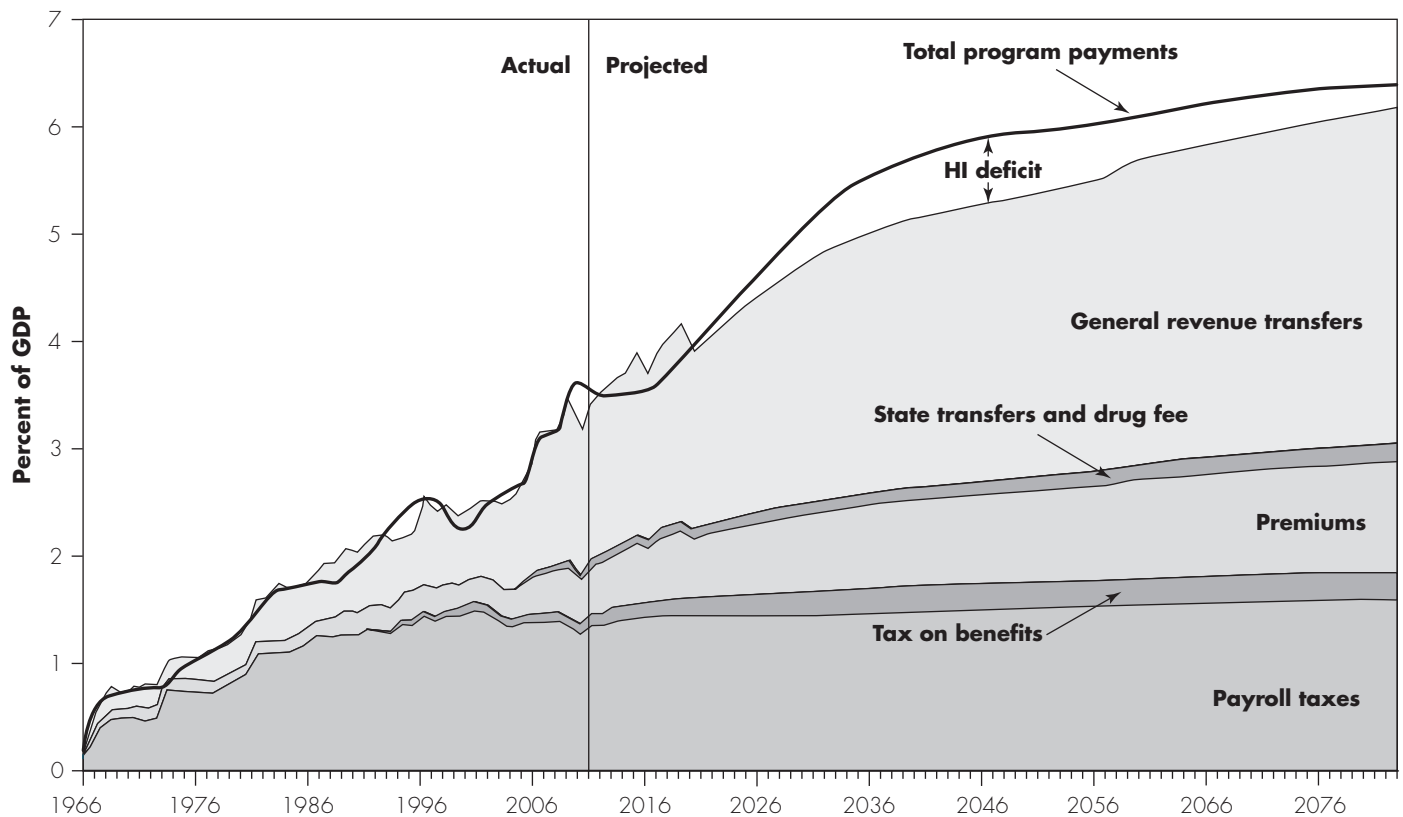
Note: GDP (gross domestic product), HI (Hospital Insurance). These projections are based on the Trustees' intermediate set of assumptions. Tax on benefits refers to a portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. State transfers (often called the Part D "clawback") refer to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending. Drug fee refers to a tax on manufacturers and importers of brand-name prescription drugs, which is credited to the Part B trust fund.

Source: 2011 annual report of the Boards of Trustees of the Medicare trust funds.

there will be continued pressure to find savings throughout the Medicare program (Figure 1-7).

Effects of Medicare's growth in spending on beneficiary out-of-pocket costs

Medicare's growth in spending and growth in health care spending overall affect beneficiaries in three ways—monthly premiums for Part B and Part D, cost sharing (coinsurance and deductibles), and out-of-pocket spending for services not covered by Medicare (such as long-term nursing home care). Approximately 90 percent of Medicare fee-for-service enrollees have additional coverage—private medigap policies, Medicaid, or

employer coverage—to supplement Medicare's traditional benefit (Medicare Payment Advisory Commission 2011a).

In 2009, the average Medicare beneficiary's cost-sharing liability was $428 for Part A and $1,188 for Part B (Medicare Payment Advisory Commission 2011a). However, most beneficiaries are insured against Medicare's cost sharing through medigap or other supplemental coverage. Growth in Medicare cost sharing is projected to continue outpacing the growth in Social Security benefits, which constitute about 40 percent of income for the median Medicare beneficiary and close to 90 percent of income for Medicare beneficiaries in the bottom two income quartiles (Figure 1-8, p. 14) (Kaiser Family Foundation 2010).

Sources of Medicare spending over the next 10 years

Growth in Medicare spending consists of three key factors: the volume and intensity of services provided per beneficiary, the prices paid by Medicare (input costs minus productivity for baseline projections), and the number of beneficiaries and their demographic profiles. These factors are subject to legislative or regulatory changes, which can affect the level of services provided per beneficiary (e.g., by covering a yearly wellness visit), the prices paid by Medicare (e.g., through annual fee schedule rulemaking), and the number of beneficiaries (e.g., by changing Medicare's eligibility age).

The Congressional Budget Office Medicare baseline projections over the next 10 years examine separately the effect of these factors—that is, the effect of enrollment, automatic price adjustments, and volume and intensity, among other trends—on growth in Medicare spending (Table 1-4). The analysis indicates that, of these factors, the per beneficiary rise in volume and intensity of services accounts for the largest share of growth in Medicare spending. One caveat is that this analysis assumes that payment rates to physicians would be cut by 30 percent in 2012. If that cut were overridden, the increase in Medicare spending due to automatic adjustments would be larger and spending in 2021 would be higher. ∎

TABLE 1–4 Sources of Medicare spending growth for 2011 through 2021 under CBO's baseline

	Dollars (in billions)
Spending in 2011	**$572**
Change in caseloads (number of beneficiaries)	43
Other changes in benefits (intensity, volume per beneficiary, and legislative changes)	306
Automatic adjustments (statutory payment updates)	115
Spending in 2021	**$1,021**

Note: CBO (Congressional Budget Office). These figures include the sustainable growth rate payment update of approximately 30 percent in 2012. Sum does not add to total due to shift in payment dates.

Source: Congressional Budget Office, *The Budget and Economic Outlook, FY 2011–2021*. Tables 3-1 and 3-4.

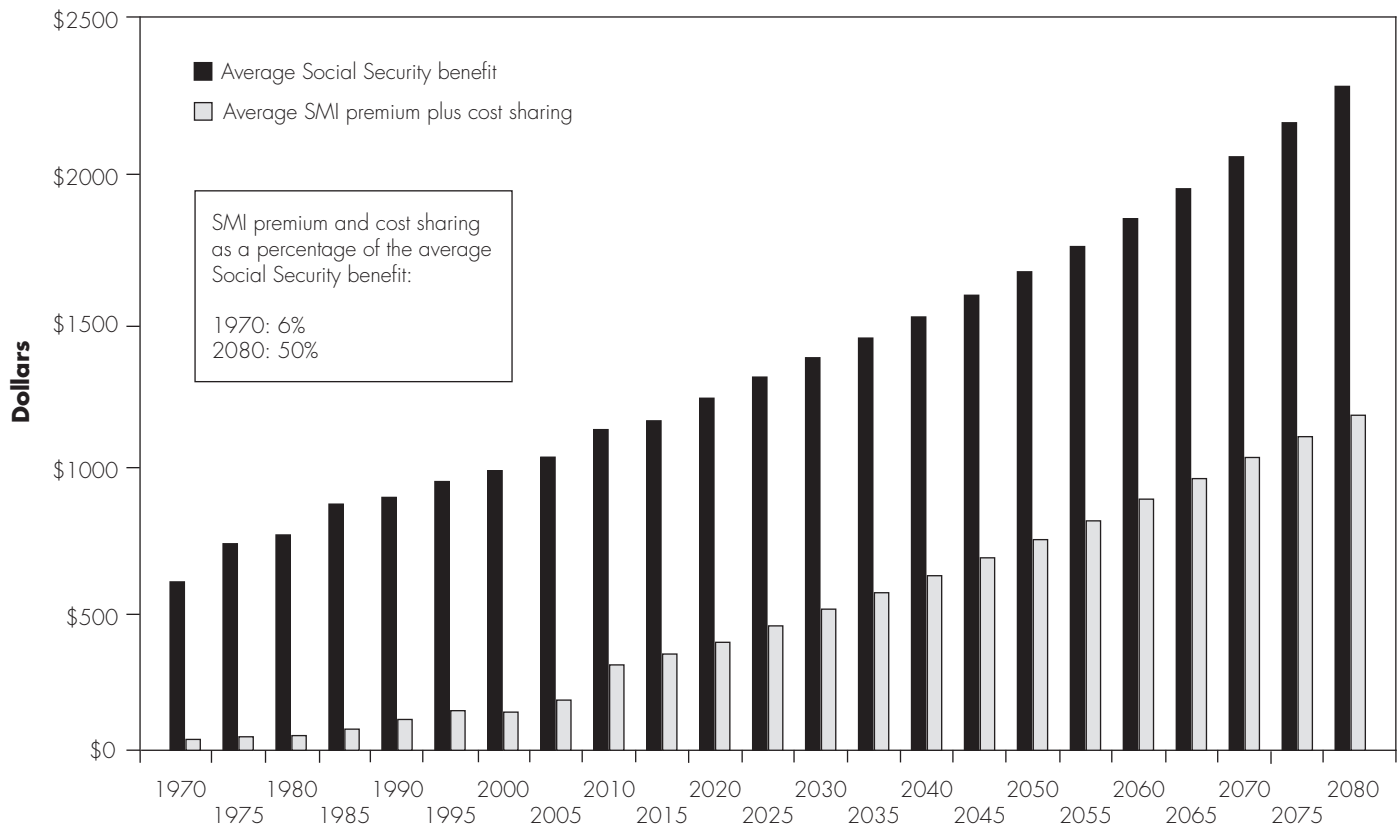## Changes in the population attaining Medicare eligibility

The Medicare population is projected to grow by a third within the next 10 years, and the population attaining eligibility in that time frame will differ in some ways from current Medicare beneficiaries. First, the Medicare population will grow younger on average over the next 10 years. Second, the income and assets of the newly eligible Medicare population could be smaller as a result of the recent economic recession and there could be rising participation in the labor force after age 65. Third, the share of people with health insurance coverage through an employer has fallen over the past 10 years, and the share of those insured through an employer with an indemnity plan has fallen nearly to zero (Kaiser Family Foundation and Health Research & Educational Trust 2011).

Age and demographic changes

As the bulk of the baby boom generation becomes eligible for Medicare, the average age of Medicare beneficiaries will decline slightly, and this effect will continue through this decade (Figure 1-9a, p. 15), when nearly a third of all Medicare beneficiaries will be between the ages of 65 and 69. Over the longer term, racial and ethnic changes among the Medicare population will be notable, with the Hispanic share of the Medicare population increasing to 14 percent by 2040 (Figure 1-9b) (Census Bureau 2008).

Household assets and attachment to the labor force

Two features of the current economic picture will be important considerations for the Medicare program, particularly in evaluating the effect of changes to

SMI premium and cost sharing
as a percentage of the average
Social Security benefit:

1970: 6%
2080: 50%

Legend:
- ■ Average Social Security benefit
- □ Average SMI premium plus cost sharing

Y-axis: Dollars ($0, $500, $1000, $1500, $2000, $2500)

X-axis years: 1970, 1975, 1980, 1985, 1990, 1995, 2000, 2005, 2010, 2015, 2020, 2025, 2030, 2035, 2040, 2045, 2050, 2055, 2060, 2065, 2070, 2075, 2080

Note: SMI (Supplementary Medical Insurance).

Source: 2011 annual report of the Boards of Trustees of the Medicare trust funds.

beneficiary cost sharing. First, the economic downturn has had an effect on the economic resources of families in or near retirement. Second, median family income for most groups has stayed relatively flat over the last decade.

In the Survey of Consumer Finances, about 60 percent of families reported a decline in family wealth between 2007 and 2009, with somewhat larger shares reporting a decline among older age brackets (Bricker et al. 2011). For many near retirees, stock market wealth is not a large share of their overall wealth, so the direct effect of the stock market decline may be muted for them (Gustman et al. 2010). However, in combination with the increase in unemployment and decline in housing value, the effect can be significant. In the American Life survey conducted

by RAND, a quarter of respondents between ages 50 and 59 indicated that they had lost more than 35 percent of their retirement savings, and 40 percent of respondents had been affected by unemployment, negative home equity, arrears on their mortgage, or foreclosure (Hurd and Rohwedder 2010).

Between 2009 and 2010, average per capita income for all families fell slightly in nominal terms ($50,599 to $49,445), while per capita income for those ages 55 to 64 declined by a similar share, from $57,914 to $56,575, on average. Overall, median family income has stayed relatively flat in nominal terms over the last decade, implying eroding purchasing power (DeNavas-Walt et al. 2011). Among the population over age 65, the share

FIGURE
1–9   Projected characteristics of the Medicare aged population

9a: Age of the Medicare aged population

9b: Race/ethnicity of the Medicare aged population
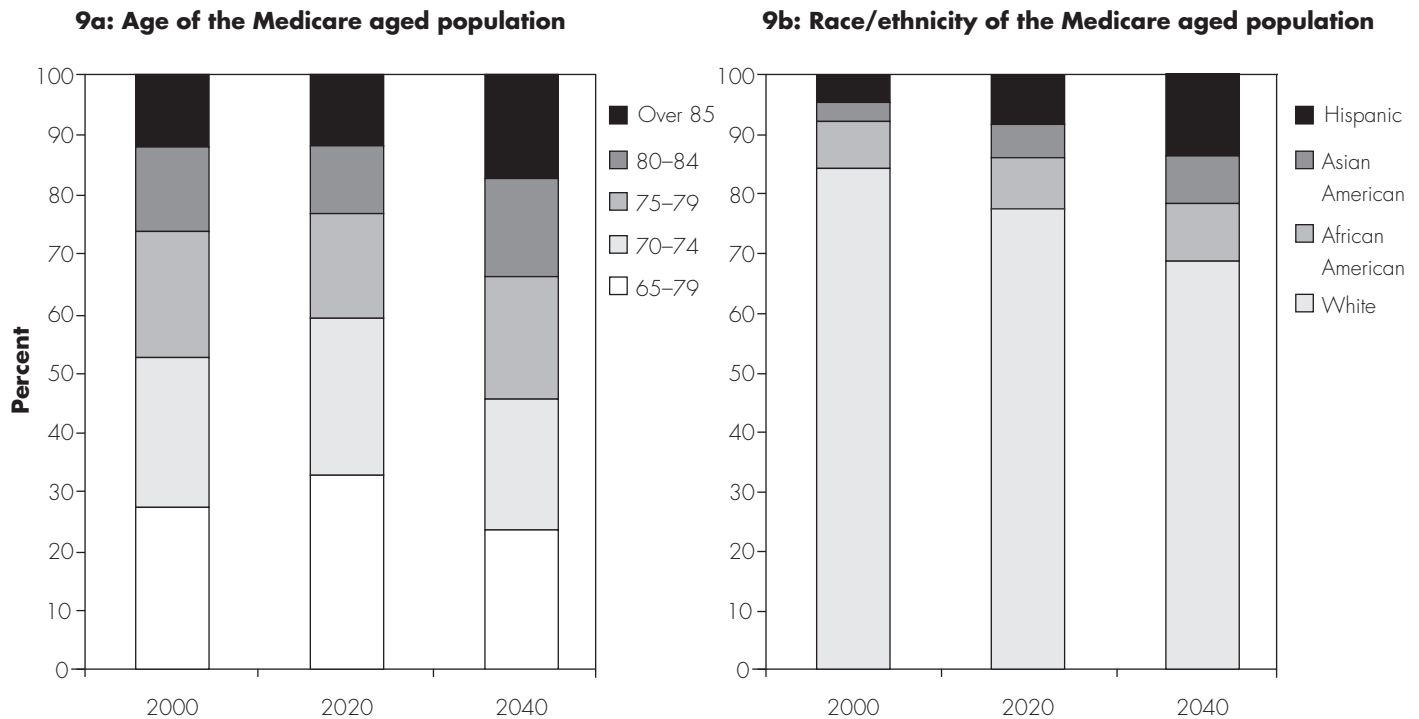
Note: Native Hawaiians and Pacific Islanders are included in the Asian American category.

Source: Census Bureau population projections.

actively in the labor force has grown over time, and this trend could be expected to continue (Figure 1-10, p. 16).

There is some evidence that the overall stagnation in net family income may be due in large part to increased spending on health care: premiums, out-of-pocket spending, and taxes for health care are estimated to have absorbed nearly all growth in real income over the prior decade for an illustrative four-person family (Auerbach and Kellermann 2011).

Insurance coverage

The share of individuals covered by employer-sponsored insurance fell from 64 percent to 55 percent between 2000 and 2010 (DeNavas-Walt et al. 2011). This drop is an effect of a decline in the share of employers offering health insurance coverage (from 68 percent in 2000 to 60 percent in 2011) and take-up by employees (84 percent in 2000 to 81 percent in 2011) (Kaiser Family Foundation and Health Research & Educational Trust 2011).

Among large firms (200 or more employees) that offer health insurance to their employees, the share offering retiree coverage fell from 34 percent to 26 percent between 2000 and 2011(Kaiser Family Foundation and Health Research & Educational Trust 2011). Of those firms that offered retiree coverage during this period, the rate offering coverage to Medicare-age retirees remained unchanged, at about 70 percent (Kaiser Family Foundation and Health Research & Educational Trust 2011).

In addition to a shift among sources of insurance coverage, the type of insurance coverage employers offer has changed over time. The share of covered employees in preferred provider organizations between 2000 and 2011 grew from 42 percent to 55 percent, while the share in conventional indemnity plans dropped from 8 percent to 1 percent and the share in HMOs fell from 29 percent to 17 percent over the same period (Kaiser Family Foundation and Health Research & Educational Trust 2011).

**FIGURE
1–10**

Employment rates among the over-65 population have grown over time
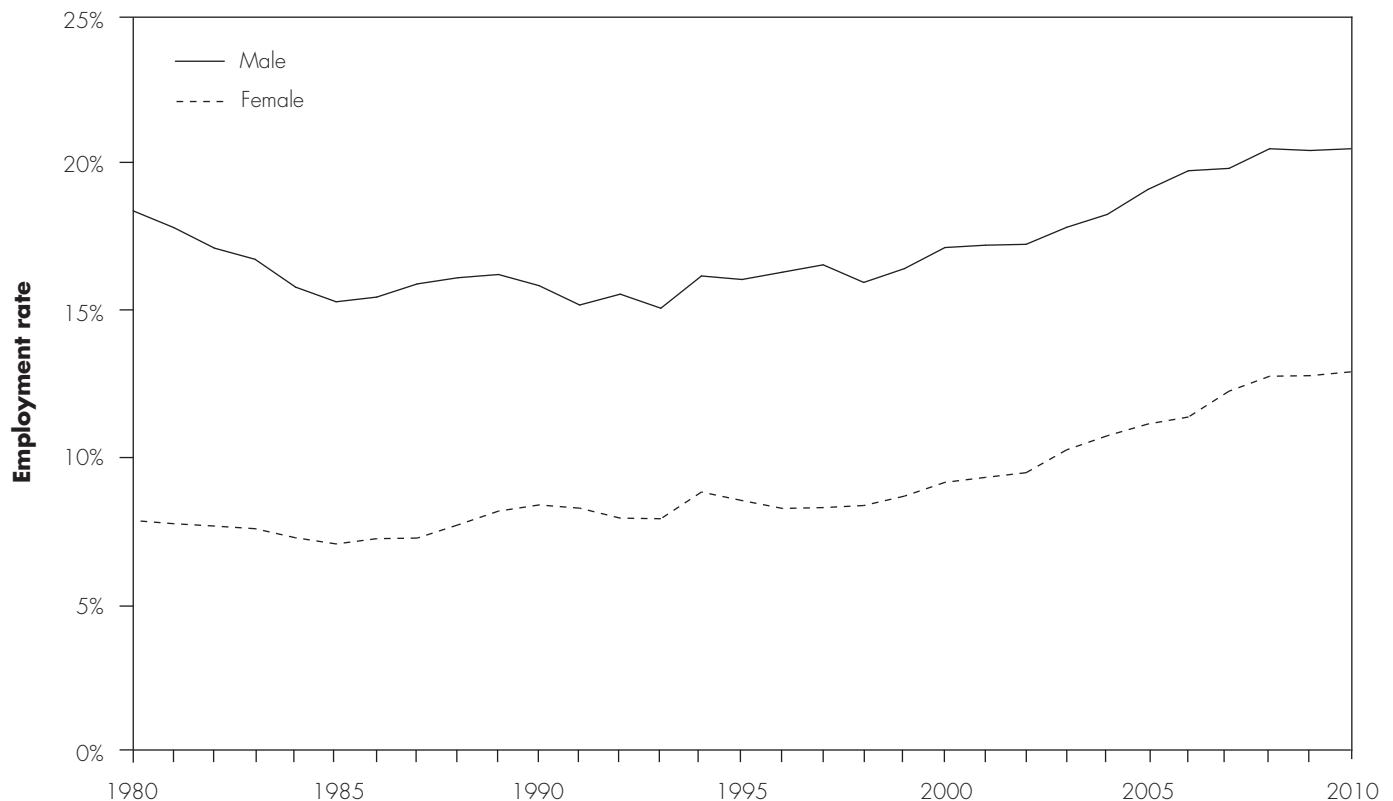
Source: Bureau of Labor Statistics, Current Employment Statistics.

Environmental scan of health care delivery system

By virtue of its size, the Medicare program has an important influence on the shape of the health care delivery system in the United States. At the same time, trends in the health care delivery system, such as industry structure and consolidation, can influence the success of, or present obstacles to, Medicare payment reforms. For example, the prospects for delivering the Medicare benefit through private plans in a market with strong provider consolidation may differ from those in a less consolidated market; analogously, a beneficiary's choice of plans may be reduced in a market with only one or two large insurers.

The health care delivery system faces notable uncertainty both as a result of the fiscal pressures facing state and local governments and because of pressures on individuals covered by private insurance resulting from growth in

health care costs. The current fiscal situation facing federal and state governments in conjunction with the slow economic recovery means that there will be significant pressure to extract additional savings from government health programs. The persistence of high rates of growth in private insurance will also create pressure for employers and workers to seek innovations that slow spending relative to historical trends.

One approach to controlling cost growth is to constrain the growth in unit payments; another approach could be to reform payment systems to reduce duplication or provide incentives for care coordination, which would lower spending. Both alternatives will increase uncertainty for providers, who may respond by looking for cost savings— for example, by being more judicious in their purchasing or by pursuing efficiencies in allocating staff resources. They might also seek to position themselves to coordinate care through new arrangements among providers such as between hospitals and physicians. As these cost controls

FIGURE
1–11   **Industry structure**
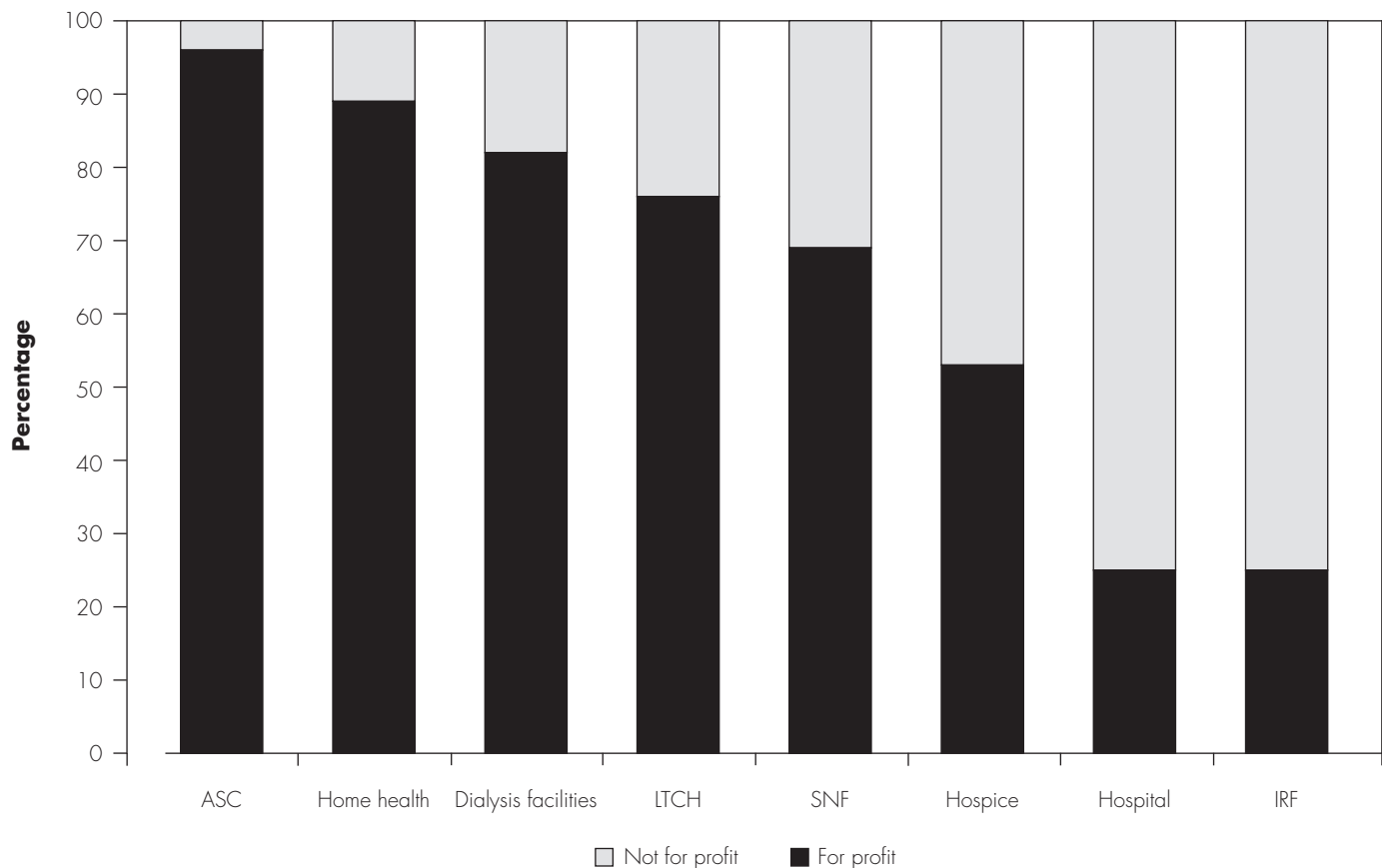
Note: ASC (ambulatory surgical center), LTCH (long-term care hospital), SNF (skilled nursing facility), IRF (inpatient rehabilitation facility).

Source: MedPAC's March 2011 report to the Congress and the June 2011 data book.

and new arrangements develop, they will in turn change the context for Medicare payment reforms. We have examined several trends in the larger health care system and changes at the federal level that can influence how Medicare will develop in the future.

Industry consolidation and structure

The health care industry varies widely across sectors and markets in how it is organized and in how strongly it is consolidated. One parameter is the degree to which sectors are controlled by for-profit versus not-for-profit (NFP) providers.

Ownership mix in the industry

For-profit providers dominate most health care sectors. As shown in Figure 1-11, ambulatory surgical centers, for example, are 96 percent for profit and the home health,

dialysis, long-term care hospital, skilled nursing facility, and hospice sectors are all over 50 percent for profit. In addition, the number of for-profit providers has increased more rapidly than the number of NFPs in many sectors. For example, the rate of growth of for-profit hospices from 2004 to 2009 was 68 percent, 10 times that of NFP hospices. For-profit long-term care hospitals saw positive growth of 18 percent from 2005 to 2009, while the number of NFPs decreased by 8 percent. Only the hospital and inpatient rehabilitation facility sectors are dominated by NFPs, with only about 25 percent for-profit providers (inpatient rehabilitation facilities are mostly hospital-based units and thus tend to mirror the distribution of hospitals).

For all sectors in which we measure margins, for-profit providers have higher Medicare margins than NFP providers. For example, in 2008, for-profit hospices had an aggregate margin of 10.0 percent in 2008 compared with

a 0.2 percent margin for NFP hospices. The predominance of for-profit providers in many sectors and their greater Medicare margins may have important implications moving forward for the prospect of cost control. On the one hand, for-profit hospitals have shown a greater ability to control costs when not under financial pressure than NFP hospitals (Medicare Payment Advisory Commission 2011c). If for-profit margins show that higher margins under Medicare rates are achievable, this may influence the perception of whether rates are adequate (assuming equivalent quality, mix of patients, and other factors). In addition, if providers come under more financial pressure, NFPs may start to control their costs more like for profits and the gap in margins may narrow. On the other hand, for profits may tend to focus their efforts on providing services that Medicare has inaccurately priced and that therefore provide more opportunity for profit. If Medicare, or the market, can reduce pricing inaccuracies, those opportunities decrease. A recent study found greater presence in a market of hospitals, skilled nursing facilities, and home health agencies organized as for profits to be modestly associated with higher total Medicare spending (Reschovsky et al. 2011). An older study concluded that both total adjusted Medicare spending and spending growth were greater in areas served by for-profit hospitals than in areas served by NFP hospitals (Silverman et al. 1999).

Private equity firms have recently moved into the hospital market. For example, Caritas Christi in Boston was bought by Cerberus Capital and the resulting Steward Health Care System has expanded from the 6 Caritas Christi hospitals to 11 hospitals. Joint ventures have also been announced by the Ascension Health Care System (the largest NFP system in the country) and Oak Hill Partners, a private equity fund. This move into the hospital sector may be part of a larger trend of investment. A recent survey suggests that private equity is aggressively investing in several health care sectors in addition to hospitals, including ambulatory surgical center chains, health care information technology, and hospices, among others (Becker et al. 2011).

Industry consolidation

The health care industry varies widely across sectors and markets in how it is organized and in how strongly it is consolidated. In some sectors, a small number of for-profit chains control a large share of facilities. For example, the two largest dialysis chains control over 60 percent of capacity in that industry and the two largest long-term care hospital chains control almost 50 percent of capacity.

The largest psychiatric hospital chain owns 102 of the 300 freestanding psychiatric hospitals.

Consolidation across markets may allow for increased economies of scale in supply chain and other functions and may also create opportunities for learning among facilities in the same system. Consolidation could also make it easier for Medicare reforms to diffuse across markets. In some cases, it may also increase the market power of facilities in the same system by forcing insurers to bargain across several markets in which a system could have dominant or "must have" providers. This effect has been noted in Northern California, where several systems now represent a large share of hospitals and can negotiate accordingly (Berenson et al. 2010).

A recent review of market consolidation of hospitals concludes that "hospital ownership in 2009 is highly concentrated in 80 percent of metropolitan statistical areas" and that the trend to greater consolidation has been continuing since the 1990s (Capps and Dranove 2011). The Federal Trade Commission has intervened several times in recent years to prevent mergers or acquisitions that it found to be anticompetitive. The concern is that consolidation can result in higher prices for commercial insurers. This issue has been raised in several recent studies including one by the Massachusetts Attorney General, which concluded that price variations are correlated with market leverage (Coakley 2010).

Employment of physicians by hospitals has also become more prevalent. The Center for Studying Health Systems Change finds that hospital employment of physicians is growing rapidly in 12 markets studied (O'Malley et al. 2011). By some estimates, almost half (49 percent) of physicians hired out of residency or fellowship were placed in hospital-owned practices (Medical Group Management Association 2010). Physicians employed by hospitals or in groups tightly associated with hospitals may benefit from the market power of the hospital when negotiating rates with insurers and may prefer the more favorable work–life balance associated with an employment-type relationship.

The development of accountable care organizations, which in some cases combine physicians, hospitals, and other providers into organizations that are accountable for the cost and quality of care for a defined population, also has implications for provider consolidation. Under Medicare, accountable care organizations can participate in the shared savings program scheduled to start in 2012. Accountable

care organizations present an opportunity to control overall costs under Medicare by controlling the volume of services and by providing greater care coordination.

Also, market domination can occur when an insurer dominates the market. In some markets, and in some entire states, one or two insurers dominate the market and can force providers to accept lower payment rates (Melnick et al. 2011). However, lower payment rates do not necessarily lead to lower premiums for consumers. If there is a lack of competition in the insurance market, insurers may be able to retain the difference between low payment rates and high premiums as profit and not pass it on to employers or individuals.

Upcoming federal policies affecting health care

In addition to the market environment for health care, changes are taking place at the federal level that will affect providers, insurers, and employers. Below is a list of some key actions and time frames.

- **Budget Control Act of 2011.** The Act established the Congressional Joint Select Committee on Deficit Reduction, which was charged with proposing legislation to reduce the deficit by at least $1.5 trillion over the next 10 years. Because the Congress did not enact legislation resulting from the Committee by January 15, 2012, to reduce the deficit by $1.2 trillion, automatic reductions (or a "sequester") will be made to discretionary and mandatory spending equal to $1.2 trillion over nine years, starting January 2, 2013. The Act limits the amount of automatic cuts for most categories of Medicare spending to 2.0 percent. The Budget Control Act also includes statutory caps through 2021 for discretionary spending (such as CMS's program management account). A special allocation (or "cap adjustment") provides additional funding above the caps of $270 million in 2012 and $3.9 billion over 10 years for the Health Care Fraud and Abuse Control program.

- **Census changes.** The 2010 decennial census will result in changes to the core-based statistical areas, which are used in Medicare payment systems. The Office of Management and Budget expects to update those areas in 2013.

- **Center for Medicare and Medicaid Innovation.** PPACA established the center to "test innovative payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care."

- **Changes for insurers.** PPACA makes a number of changes to the rules for insurers. CMS and the Departments of Treasury and Labor issued rules in 2010 subjecting insurers in the individual and small group markets to regulations on the plans' medical loss ratios, guaranteed issue, benefit caps, and grandfathered plans. By 2014, all plans in the individual and group markets will be prohibited from writing coverage that would exclude preexisting conditions, deny coverage based on medical conditions, use medical underwriting, or have waiting periods. All plans must offer an essential benefit package, and risk sharing in the individual and small group market will also start in 2014.

- **Coverage expansions.** Under PPACA, starting in 2014, nearly all individuals under age 65 with incomes less than 138 percent of the federal poverty threshold will be eligible for Medicaid. The state exchanges will aggregate private health insurance options, individuals and families with incomes up to 400 percent of the federal poverty threshold will be eligible for premium subsidies through the income tax system, and individuals and families with income up to 250 percent of the federal poverty threshold will be eligible for cost-sharing subsidies. Most individuals must obtain qualifying health insurance coverage or pay a penalty through the tax system. The coverage expansions could have a significant effect on providers, by changing the mix of payers of the patients they see (and resulting reimbursement).[7]

- **Employer coverage.** PPACA institutes penalties for larger employers whose employees receive subsidized health insurance in the exchange. An excise tax of 40 percent goes into effect for high-cost employer-sponsored insurance in 2018.

- **Federal financing.** The Recovery Act provided payment incentives to encourage hospitals and physicians to adopt electronic health record technology. These payments for the technology began in fiscal year 2011 and will continue each year until fiscal year 2017. Starting in 2015, eligible hospitals and physicians who do not satisfy electronic health record "meaningful use" criteria specified by CMS will be subject to a Medicare payment reduction.

- ***Independent Payment Advisory Board.*** PPACA created the Independent Payment Advisory Board to reduce the per capita rate of growth in Medicare spending. Starting in 2013, subject to a determination by the CMS Chief Actuary that the per capita Medicare spending exceeds certain targets set out in the law, the Board is to develop a proposal to reduce the Medicare growth rate. Absent further action, the Secretary of the Department of Health and Human Services is directed to implement the board's proposals.

- ***Medicaid.*** The provisions in the Recovery Act providing a higher level of federal Medicaid matching funds to states were extended through June 2011 and have now expired. States are currently under maintenance of effort requirements until the coverage expansions are put in place in 2014, limiting their ability to cut Medicaid spending or reduce enrollment.

- ***Tax changes.*** Under PPACA, the expanded HI tax (0.9 percent for individuals making more than $200,000) takes effect in 2013, and an additional Medicare contribution applies to investment income in 2013. A fee is imposed on (1) pharmaceutical companies in 2011, (2) medical device manufacturers in 2013, and (3) insurance providers in 2014.

Reasons for growth in health care spending

As previously noted, per capita or per enrollee health care spending has grown at least 2 percentage points faster than economic growth, and these trends persist across all payers. Understanding the reasons for the growth in health care spending is critical to successfully designing interventions to slow it.

However, measuring the effect of different factors on growth in health care costs is challenging. First, health care prices vary for many reasons, beyond the costs of inputs. Second, the interactive relationship of certain factors, such as insurance coverage and technology, make attribution to individual factors difficult. Third, many researchers use the term "technology" to cover all unexplained growth beyond aging, insurance, and other discrete factors. As a result, the term technology generally encompasses nearly all changes to the practice of medicine.[8] With these caveats, the factors affecting growth in health care spending are still well agreed upon, even if the share attributable to each factor is debated (Congressional Budget Office 2011b, Smith et al. 2009).

Further complicating efforts to decompose health care spending is that some factors are believed to affect the high growth rate of health care spending, while others are believed to contribute to the high level of health care spending, and others are believed to affect both the level and growth.

Technology

The introduction, expansion, and diffusion of new technology are credited with having the largest single effect on growth in health care spending. Technologies in this context include a new intervention or treatment, changes in procedures or process, and changes in the appropriate population for a treatment. Several downstream effects are also often incorporated in this definition of technology. First, it can include expanding an intervention to new populations as well as the tools to profile and target the intervention to the appropriate population. Second, when an intervention either increases or reduces the use of other treatments, these effects are included (Chernew 2010, Cutler and McClellan 2001). Third, a technological intervention can result in higher overall population spending if it makes it possible to survive a previously terminal condition (McKinsey Global Institute 2008).

This broad definition of technology is often used because current research methods, while distinguishing among other spending factors—such as income, insurance, and demographics—often cannot separate the downstream effects of using a new drug, device, or treatment from its introduction into clinical practice (Chernew 2010, Congressional Budget Office 2008).

Price

Identifying the effect of prices on growth in health care spending is challenging because of measurement problems in defining both inputs and outputs. Prices are often not transparent and can vary across geographic areas, payers, and providers for the same service. Studies of the health care system across countries have found that prices for health care products in the United States are higher than in other countries (Anderson et al. 2003, Anderson et al. 2005). Higher prices may also result from a lack of competition in a region or for a specific service or product.

Competition and regulation

The evidence of competition on growth in total health care spending is mixed, although many researchers believe that markets with provider consolidation (or with less competition) may have faster growth in health care spending (Vogt and Town 2006). Researchers have shown that providers have obtained market power to negotiate higher payer rates (Berenson et al. 2010) and that increased integration has led to higher prices for health care services in hospital markets (Capps and Dranove 2004, Dranove et al. 1993, Vogt and Town 2006). Moriya and colleagues found that increases in insurance market concentration significantly decreased hospital prices, while hospital concentration resulted in higher prices, although the latter effect was not significant (Moriya et al. 2010). Finally, consolidation in the insurer market (Robinson 2004) has resulted in many markets with a few dominant providers and a few dominant payers (Ginsburg and Lesser 2006).

Another feature often mentioned as having the potential to slow growth in health care spending is regulation through administered pricing. However, as presented earlier, the growth rates for public and private health payers are similar, implying that neither competition (as it currently exists in the private market for health care) nor the government's ability to set prices (as it currently exists for Medicare and Medicaid) has successfully constrained growth in health care spending.

Health insurance

The scope of health insurance coverage is also believed to contribute to growth in health care spending (Feldstein 1973, Manning et al. 1987). Being insured against the cost of a health care intervention, when coupled with the lack of complete information about the marginal effectiveness, could result in less incentive to seek the lowest priced effective care. Some researchers also postulate that technology and health insurance work in tandem to drive growth in health care spending. For example, Finkelstein studied the introduction of the Medicare program and growth in health care spending and found that the effect of the spread of health insurance more generally from 1950 through 1990 could explain up to half of the increase in per capita health care spending over this time period (Finkelstein 2007).

Income, wealth, and demographics also affect spending growth

Increases in national income and wealth also contribute to growth in health care spending, and, like insurance, the interaction effects between income and other factors could be significant. Smith and colleagues found that national income growth worked in tandem with expanding insurance coverage to drive technological change in health care (Smith et al. 2009). The aging of the population and changes in health status also affect the rate of growth of health care spending, although to a smaller extent than technology.

National and international variation in health care spending suggests inefficiencies

As Medicare is the largest single purchaser of health care in the United States, it is important to review the evidence that some health care spending is inefficient—that it does not improve the population's health or ultimate outcomes, or that it is inefficiently allocated across populations or regions. First, although assessing the value of health care is difficult, many researchers believe that the value of the marginal dollar spent on health care is declining over time (Cutler et al. 2006). Second, despite years of attention to disparities in the delivery of health care, outcomes are still worse for individuals in racial and ethnic minorities and for those with low incomes (Agency for Healthcare Research and Quality 2011). Finally, many observers contend that the lack of consistently better health outcomes—despite higher per capita spending relative to other countries—is evidence of inefficiency in U.S. health expenditures (Anderson and Frogner 2008).

Value of health care

Researchers use a couple of approaches to assess the value of health care spending. Some analyses evaluate the effect of the total increase in spending on a macro-level indicator, such as mortality or life expectancy. One study that took this approach found that the increase in health care spending from 1960 to 2000 provided reasonable value. However, the study also noted that the value of health care spending appeared to be decreasing over time, particularly among the elderly (Cutler et al. 2006). Other approaches review the marginal improvement in health for a specific disease, finding that the improvement in outcomes after heart attacks was worth the increase in spending (Cutler and McClellan 2001).

Even when an intervention is effective in a clearly defined population, it is often diffused far more widely to populations for whom the effectiveness is not well established (Garber et al. 2007). This practice can lead

to higher spending (and faster growth in spending as the intervention is diffused across populations for whom a lower cost, less invasive method may be available) and lower value for the additional cost. For example, a study of screening colonoscopies among the Medicare population found that 46 percent of the population who received a negative screening colonoscopy received another screening within seven years, even though expert panels recommend that screening colonoscopies be repeated no more frequently than 10 years after a negative test (Goodwin et al. 2011).

Wide variation in spending and use of care provided across the country and within regions

Geographic variation in the amount of health care received and spending on health care is notable, which cannot be fully explained by difference in disease burden, severity, or supply (Fisher et al. 2003a, Fisher et al. 2003b, Medicare Payment Advisory Commission 2011d, Zhang et al. 2010, Zuckerman et al. 2010). However, it is not the case that only areas with high spending have inappropriate care—it appears that areas with both high and low spending have some level of appropriate and inappropriate care (Chassin et al. 1987, Leape et al. 1993).

The Commission's work on geographic variation found significant variation even among the use of services for comparable populations. Variation in total Medicare spending between the 90th percentile and the 10th percentile of metropolitan statistical areas was 55 percent; taking out Medicare's explicit price adjustments and special payments reduces this variation to 44 percent, and further adjusting for health status—resulting in a measure of service use rather than spending—reduces variation to 30 percent (Medicare Payment Advisory Commission 2011d). Furthermore, variation in post-acute sector services (such as home health care and durable medical equipment) is particularly high and those services disproportionately contribute to overall variation (Medicare Payment Advisory Commission 2011d). Finally, work on physician resource use has found significant variation among physicians in the same geographic area and specialty—physicians at the 90th percentile had resource use between 40 percent and 60 percent higher than the median physician in the same specialty and geographic area treating the same condition (Houchens 2010). Wide variation in the amount of care persists even when observable characteristics are accounted for.

Disparities across populations

Notable differences in access to quality care for different demographic groups are of concern to the Commission. First, as described in our June 2011 report in the chapter on quality improvement, Medicare beneficiaries in racial and ethnic minorities or with low income are more likely to seek care from poorer quality providers (Bach et al. 2004, Jha et al. 2007, Medicare Payment Advisory Commission 2011b). Furthermore, racial and ethnic minorities tend to have poorer outcomes, depending on where they receive their care; for example, risk-adjusted mortality after acute myocardial infarction was higher in hospitals that treated African Americans at a higher rate (Skinner et al. 2001) and the risk of admission to a high-mortality hospital was 35 percent higher for African Americans than for whites in a market with high racial segregation (Sarrazin et al. 2009).

Differences also exist in general treatment patterns and in where facilities and other health care resources are likely to locate. First, low-income individuals are more likely to use the emergency department than other ambulatory care settings (Tang et al. 2010). Second, closure of facilities can be related to racial, ethnic, and income characteristics of the neighborhood—one study found that being located in a poor area or serving a predominantly lower income population was correlated with a greater chance of emergency department closure, and nursing home closures were more prevalent in areas with a higher proportion of African Americans or minorities and a larger share of residents in poverty (Feng et al. 2011, Hsia et al. 2011).

A meta-analysis of health literacy conducted for the Agency for Healthcare Research and Quality found that low health literacy resulted in increased use of high-intensity sites (such as hospitals and emergency departments), worse health outcomes (including higher mortality and poorer overall health status), and lower levels of prevention screening. Using the definition of health literacy in this analysis, low health literacy was disproportionately high among the elderly, racial and ethnic minorities, those with low education levels, and people in poverty (Berkman et al. 2011). The persistence of poorer outcomes for racial and ethnic minorities and those who are low income indicates that, even with the high level of spending in the United States, gaps in the quality of care exist.

FIGURE
1–12

Health care spending as a share of GDP, 1970 and 2008
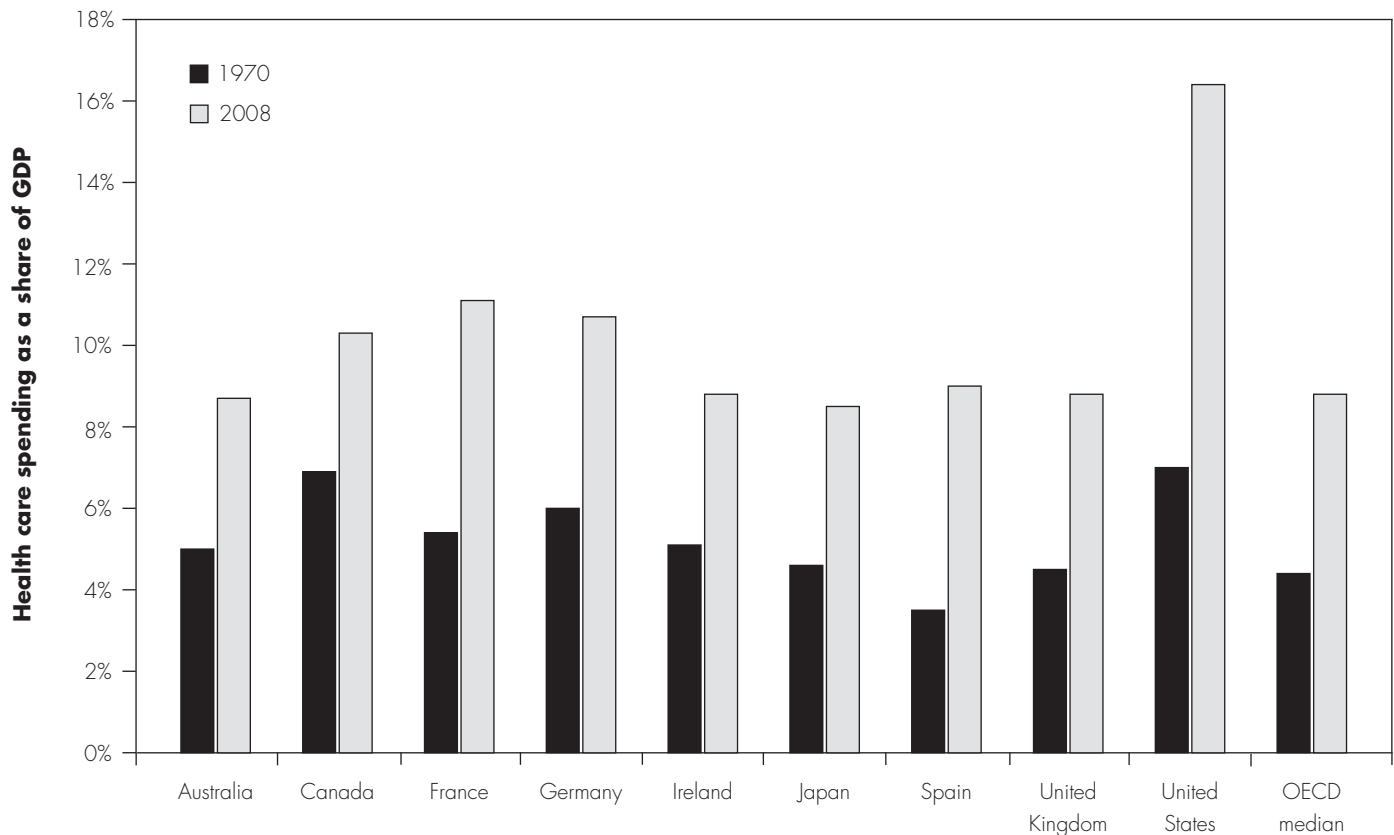
Note: GDP (gross domestic product).

Source: Anderson and Frogner 2008 and the Organisation for Economic Co-operation and Development.

Level and growth of health care spending in the United States exceeds that in other developed countries

The level of health care spending, measured as per capita spending, share of GDP, or spending adjusted for purchasing power, is much higher in the United States than in other Organisation for Economic Co-operation and Development (OECD) countries. Furthermore, health care spending as a share of GDP has grown faster in the United States than in other countries, growing at 2 percentage points above economic growth between 1970 and 2008, while in other OECD countries it grew at rates closer to 1 percentage point above economic growth (Figure 1-12) (White 2007).

Comparing the United States and other countries on health outcomes is challenging because measures such as life expectancy incorporate differences outside the health care

system, such as lifestyle and socioeconomic status, disease burden, and accident rates (Docteur and Berenson 2009). However, life expectancy at age 65 in the United States is roughly in the middle of all OECD countries (Docteur and Berenson 2009) and U.S. survival rates have not improved as fast as in some OECD countries, even when factors such as smoking, obesity, and population diversity are taken into account (Muennig and Glied 2010). The technical quality of care in the United States is also mixed for preventive, chronic, and acute care, with relatively high quality of care for cancer but relatively lower quality of care for chronic conditions amenable to treatment (Docteur and Berenson 2009).

Overall, compared with the United States, other OECD countries appear to obtain similar or better outcomes with significantly lower total spending (Anderson and Squires 2010). In fact, public health care spending in the

United States is essentially equivalent to what the median OECD country spends on public and private health care combined (Squires 2011).

Conclusion

Health care's growth as a share of the economy means that an ever-increasing amount of economic gain goes to purchase additional health care. While it appears that on average the aggregate increase in health care spending has improved well-being, there is some evidence that a share of health care spending does not improve health or that the marginal benefit is declining (Cutler et al. 2006, Skinner et al. 2001).The presence of significant variation that does not correspond to better quality also raises flags that a considerable share of medical spending is not improving overall welfare. While explicit fraud and abuse make up some of the misuse in health care, it appears that a much larger share of health care spending is misspent and does not improve ultimate outcomes (Schuster et al. 2005).

Despite the relatively lower growth rates projected for the Medicare program under current law, the program will still continue to absorb high and growing levels of federal revenues. The current fiscal pressure facing federal and state budgets, in combination with the downward pressure of growth in health care costs on income, underscores the importance of ensuring that Medicare is a wise purchaser of health care. ■

Endnotes

1   The National Health Expenditure data—collected by CMS, the Census Bureau, and the Bureau of Economic Analysis— track health spending in the United States. There are two dimensions: spending for health care goods and services and the programs and other payers that purchase those goods and services.

2   The value of the federal tax exclusion for employer-sponsored health insurance was estimated to be $160 billion in 2010, according to the 2012 President's budget.

3   These figures exclude the effect of the deficit reduction resulting from the Budget Control Act of 2011.

4   CBO's long-range health care assumptions are 1.2 percentage points above GDP growth for Medicare and 0.8 percentage point above GDP growth for Medicaid on average over the 2022–2085 period.

5   The per capita growth rate for Part A and Part B, excluding Part D, from 2001 to 2010 is about 5.4 percent.

6   Over the long term, the Trustees assume that Medicare spending per beneficiary will grow by GDP minus 0.1 percentage point for Part A and Part B, or about 4 percent annually. Part D, which is not affected by a productivity adjustment, is projected to grow at GDP plus 1 percentage point, which is roughly 5.1 percent on average. These growth rates are smaller than the Trustees' long-range projections before PPACA (which was GDP plus 1 percentage point) and smaller than historical trends in Medicare per beneficiary spending, which have averaged about GDP plus 2 percentage points (Boards of Trustees 2011).

7   For example, the coverage expansions could result in fewer bad debts for providers if their uninsured patients are now covered by insurance.

8   One example is changing guidelines for cancer screening.

References

Agency for Healthcare Research and Quality, Department of Health and Human Services. 2011. *National healthcare disparities report 2010.* Rockville, MD: AHRQ.

Anderson, G. F., and B. K. Frogner. 2008. Health spending in OECD countries: Obtaining value per dollar. *Health Affairs* 27, no. 6 (November–December): 1718–1727.

Anderson, G. F., P. S. Hussey, B. K. Frogner, et al. 2005. Health spending in the United States and the rest of the industrialized world. *Health Affairs* 24, no. 4 (July–August): 903–914.

Anderson, G. F., U. E. Reinhardt, P. S. Hussey, et al. 2003. It's the prices, stupid: Why the United States is so different from other countries. *Health Affairs* 22, no. 3 (May–June): 89–105.

Anderson, G. F., and D. A. Squires. 2010. *Measuring the U.S. health care system: A cross-national comparison.* New York: The Commonwealth Fund.

Auerbach, D. I., and A. L. Kellermann. 2011. A decade of health care cost growth has wiped out real income gains for an average US family. *Health Affairs* 30, no. 9 (September): 1630–1636.

Bach, P. B., H. H. Pham, D. Schrag, et al. 2004. Primary care physicians who treat blacks and whites. *New England Journal of Medicine* 351, no. 6: 575–584.

Becker, S., K. Werling, and H. Carnell. 2011. Private equity investing in healthcare—13 hot and 4 cold areas. *Becker's Hospital Review*, August 16.

Berenson, R. A., P. B. Ginsburg, and N. Kemper. 2010. Unchecked provider clout in California foreshadows challenges to health reform. *Health Affairs* 29, no. 4 (April): 699–705.

Berkman, N. D., S. L. Sheridan, K. E. Donahue, et al. 2011. *Health literacy interventions and outcomes: An updated systematic review.* Evidence report/technology assessment no. 199. Rockville, MD: Agency for Healthcare Research and Quality.

Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2011. *2011 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds.* Washington, DC: Boards of Trustees.

Bricker, J., B. Bucks, A. Kennickell, et al. 2011. *Surveying the aftermath of the storm: Changes in family finances from 2007 to 2009.* Staff working paper. Finance and economics discussion series. Washington, DC: Federal Reserve Board.

Capps, C., and D. Dranove. 2004. Hospital consolidation and negotiated PPO prices. *Health Affairs* 23, no. 2 (March–April): 175–181.

Capps, C., and D. Dranove. 2011. Market concentration of hospitals. An analysis performed by Bates White Economic Consulting for America's Health Insurance Plans.

Census Bureau, Department of Commerce. 2008. National population projections. http://www.census.gov/population/www/projections/downloadablefiles.html.

Chassin, M. R., J. Kosecoff, D. H. Solomon, et al. 1987. How coronary angiography is used. Clinical determinants of appropriateness. *Journal of the American Medical Association* 258, no. 18 (November 13): 2543–2547.

Chernew, M. 2010. Health care spending growth: Can we avoid fiscal Armageddon? *Inquiry* 47, no. 4 (Winter): 285–295.

Coakley, M. 2010. *Examination of health care cost trends and cost drivers.* Boston, MA: Office of the Massachusetts Attorney General.

Congressional Budget Office. 2008. *Technological change and the growth of health care spending.* Washington, DC: CBO.

Congressional Budget Office. 2011a. *Budget and economic outlook: An update.* Washington, DC: CBO.

Congressional Budget Office. 2011b. *CBO's 2011 long-term budget outlook.* Washington, DC: CBO.

Cutler, D. M., and M. McClellan. 2001. Is technological change in medicine worth it? *Health Affairs* 20, no. 5 (September–October): 11–29.

Cutler, D. M., A. B. Rosen, and S. Vijan. 2006. The value of medical spending in the United States, 1960–2000. *New England Journal of Medicine* 355, no. 9 (August 31): 920–927.

DeNavas-Walt, C., B. D. Proctor, and J. C. Smith. 2011. *Income, poverty, and health insurance coverage in the United States: 2010.* Current population reports: Consumer income. Washington, DC: Census Bureau.

Docteur, E., and R. Berenson. 2009. *How does U.S. health care compare internationally?* Washington, DC: Urban Institute.

Dranove, D., M. Shanley, and W. D. White. 1993. Price and concentration in hospital markets: The switch from patient-driven to payer-driven competition. *Journal of Law and Economics* 36, no. 1: 179–204.

MedPAC

Feldstein, M. 1973. The welfare loss of excess health insurance. *The Journal of Political Economy* 81, no. 2 (March–April): 251–280.

Feng, Z., M. Lepore, M. A. Clark, et al. 2011. Geographic concentration and correlates of nursing home closures: 1999–2008. *Archives of Internal Medicine* 171, no. 9 (May 9): 806–813.

Finkelstein, A. 2007. The aggregate effects of health insurance: Evidence from the introduction of Medicare. *Quarterly Journal of Economics* 122, no. 1: 1–37.

Fisher, E. S., D. E. Wennberg, T. A. Stukel, et al. 2003a. The implications of regional variations in Medicare spending. Part 1: The content, quality, and accessibility of care. *Annals of Internal Medicine* 138, no. 4 (February 18): 273–287.

Fisher, E. S., D. E. Wennberg, T. A. Stukel, et al. 2003b. The implications of regional variations in Medicare spending. Part 2: Health outcomes and satisfaction with care. *Annals of Internal Medicine* 138, no. 4 (February 18): 288–298.

Garber, A., D. P. Goldman, and A. B. Jena. 2007. The promise of health care cost containment. *Health Affairs* 26, no. 6 (November–December): 1545–1547.

Ginsburg, P. B., and C. Lesser. 2006. *A decade of tracking health system change.* Commentary no. 2. Washington, DC: Center for Studying Health System Change.

Goodwin, J. S., A. Singh, N. Reddy, et al. 2011. Overuse of screening colonoscopy in the Medicare population. *Archives of Internal Medicine* 171, no. 15 (August 8): 1335–1343.

Gustman, A. L., T. L. Steinmeier, and N. Tabatabai. 2010. What the stock market decline means for the financial security and retirement choices of the near-retirement population. *Journal of Economic Perspectives* 24, no. 1: 161–182.

Houchens, R. 2010. *The reliability of physician cost profiling in Medicare.* Report prepared by staff from Thomson Reuters for the Medicare Payment Advisory Commission. Washington, DC: MedPAC.

Hsia, R. Y., A. L. Kellermann, and Y. C. Shen. 2011. Factors associated with closures of emergency departments in the United States. *Journal of the American Medical Association* 305, no. 19 (May 18): 1978–1985.

Hurd, M., and S. Rohwedder. 2010. *Effect of the financial crisis and great recession on American households.* Working paper WR–810. Santa Monica, CA: RAND Corporation.

Jha, A. K., E. J. Orav, Z. Li, et al. 2007. Concentration and quality of hospitals that care for elderly black patients. *Archives of Internal Medicine* 167, no. 11 (June 11): 1177–1182.

Kaiser Family Foundation. 2010. *Medicare chartbook, fourth edition, 2010.* Washington, DC: KFF.

Kaiser Family Foundation. 2011. State health facts. http://www.statehealthfacts.org/comparecat.jsp?cat=6&rgn=6&rgn=1.

Kaiser Family Foundation and Health Research & Educational Trust. 2011. *Employer health benefits: 2011 annual survey.* Menlo Park, CA: Kaiser Family Foundation HRET.

Keehan, S. P., A. M. Sisko, C. J. Truffer, et al. 2011. National health spending projections through 2020: Economic recovery and reform drive faster spending growth. *Health Affairs* 30, no. 8 (August): 1594–1605.

Leape, L. L., L. H. Hilborne, R. E. Park, et al. 1993. The appropriateness of use of coronary artery bypass graft surgery in New York State. *Journal of the American Medical Association* 269, no. 6 (February 10): 753–760.

Manning, W. G., J. P. Newhouse, N. Duan, et al. 1987. Health insurance and the demand for medical care: Evidence from a randomized experiment. *The American Economic Review* 77, no. 3 (June): 251–277.

Martin, A. B., D. Lassman, B. Washington, et al. 2012. Growth in US health spending remained slow in 2010; health share of gross domestic product was unchanged from 2009. *Health Affairs* 31, no. 1 (January): 208–219.

McKinsey Global Institute. 2008. *Accounting for the cost of U.S. health care: A new look at why Americans spend more.* New York: McKinsey and Company.

Medicaid and CHIP Payment and Access Commission. 2011a. *The evolution of managed care in Medicaid.* Washington, DC: MACPAC.

Medicaid and CHIP Payment and Access Commission. 2011b. *MACStats in PDF format.* Washington, DC: MACPAC.

Medicaid and CHIP Payment and Access Commission. 2011c. *March 2011 report to the Congress on Medicaid and CHIP.* Washington, DC: MACPAC.

Medical Group Management Association. 2010. *Physician placement starting salary survey: 2010 report based on 2009 data.* Washington, DC: MGMA.

Medicare Payment Advisory Commission. 2011a. *A data book: Healthcare spending and the Medicare program.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2011b. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2011c. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2011d. *Report to the Congress: Regional variation in Medicare service use.* Washington, DC: MedPAC.

Melnick, G. A., Y. C. Shen, and V. Y. Wu. 2011. The increased concentration of health plan markets can benefit consumers through lower hospital prices. *Health Affairs* 30, no. 9 (September): 1728–1733.

Moriya, A. S., W. B. Vogt, and M. Gaynor. 2010. Hospital prices and market structure in the hospital and insurance industries. *Health Economics, Policy and Law* 5, no. 4 (October): 459–479.

Muennig, P. A., and S. A. Glied. 2010. What changes in survival rates tell us about us health care. *Health Affairs* 29, no. 11 (November): 2105–2113.

O'Malley, A. S., A. M. Bond, and R. A. Berenson. 2011. *Hospital employment of physicians: better quality, higher costs?* Issue brief no. 136. Washington, DC: Center for Studying Health System Change.

Pew Center on the States. 2010. *State of the states 2010: How the recession might change states.* Washington, DC: Pew Center on the States.

Reschovsky, J. D., J. Hadley, C. B. Saiontz-Martinez, et al. 2011. Following the money: Factors associated with the cost of treating high-cost Medicare beneficiaries. *Health Services Research* 46, no. 4 (August): 997–1021.

Robinson, J. C. 2004. Consolidation and the transformation of competition in health insurance. *Health Affairs* 23, no. 6 (November–December): 11–24.

Sarrazin, M. V., M. Campbell, and G. E. Rosenthal. 2009. Racial differences in hospital use after acute myocardial infarction: Does residential segregation play a role? *Health Affairs* 28, no. 2 (March–April): w368–378.

Schuster, M. A., E. A. McGlynn, and R. H. Brook. 2005. How good is the quality of health care in the United States? 1998. *Milbank Quarterly* 83, no. 4: 843–895.

Shatto, J. D., and M. K. Clemens. 2011. Projected Medicare expenditures under an illustrative scenario with alternative payment updates to Medicare providers. Memorandum from the Centers for Medicare & Medicaid Services, Office of the Actuary. May 13.

Silverman, E. M., J. S. Skinner, and E. S. Fisher. 1999. The association between for-profit hospital ownership and increased Medicare spending. *New England Journal of Medicine* 341, no. 6 (August 5): 420–426.

Skinner, J., E. S. Fisher, and J. E. Wennberg. 2001. *The efficiency of Medicare.* Working paper 8395. Cambridge, MA: National Bureau of Economic Research.

Smith, S. D., J. P. Newhouse, and M. S. Freeland. 2009. Income, insurance, and technology: Why does health spending outpace economic growth? *Health Affairs* 28, no. 5 (September–October): 1276–1284.

Squires, D. A. 2011. *The U.S. health system in perspective: A comparison of twelve industrialized nations.* New York: The Commonwealth Fund.

Tang, N., J. Stein, R. Y. Hsia, et al. 2010. Trends and characteristics of US emergency department visits, 1997–2007. *Journal of the American Medical Association* 304, no. 6 (August 11): 664–670.

Vogt, W., and R. Town. 2006. *How has hospital consolidation affected the price and quality of health care?* Issue brief no. 9. Princeton, NJ: Robert Wood Johnson Foundation. February.

White, C. 2007. Health care spending growth: How different is the United States from the rest of the OECD? *Health Affairs* 26, no. 1 (January–February): 154–161.

Zhang, Y., K. Baicker, and J. P. Newhouse. 2010. Geographic variation in Medicare drug spending. *New England Journal of Medicine* 363, no. 5 (July 29): 405–409.

Zuckerman, S., T. Waidmann, R. Berenson, et al. 2010. Clarifying sources of geographic differences in Medicare spending. *New England Journal of Medicine* 363, no. 1 (July 1): 54–62.